IOWA PHARMACIST LICENSE RENEWAL APPLICATION

Complete the attached Iowa Board of Pharmacy's pharmacist license renewal application. This application is not to be used for nonresident pharmacy PIC registration renewals. When completing this application, please be advised of the following:

- All sections of the application must be completed. **Incomplete applications will delay the renewal of your license.** Unsigned applications will be returned.
- Failure to answer all questions completely or accurately, and/or omission or falsification of material facts may be cause for denial of your application or disciplinary action. If you are in doubt, answer "yes" and provide an explanation.

Continuing Education Activity Topics:

A minimum of 15 contact hours of the pharmacist's required 30 contact hours must be in ACPE-accredited provider activities dealing with drug therapy. Activities qualifying for the drug therapy requirement will include the ACPE topic designator "01" or "02" followed by the letter "P" at the end of the universal activity number.

A minimum of 2 contact hours of the pharmacist's required 30 contact hours must be in ACPE-accredited provider activities dealing with pharmacy law. Activities qualifying for the pharmacy law requirement will include the ACPE topic designator "03" followed by the letter "P" at the end of the universal activity number.

A minimum of 2 contact hours of the pharmacist's required 30 contact hours must be in activities dealing with patient or medication safety. Activities completed to fulfill this requirement may be ACPE-accredited provider activities, in which case the universal activity number will end with the ACPE topic designator "05" followed by the letter "P." A pharmacist may complete non-ACPE provider activities as provided in paragraph 2.12(2)"a" to fulfill this topic requirement.

An authorized pharmacist who engages in the administration of vaccines must complete and document at least one hour of ACPE-approved continuing education with the ACPE topic designator "06" followed by the letter "P."

During any periods which the pharmacist engages in the administration of vaccines, the pharmacist must maintain current certification in basic cardiac life support through a training program designated for health care providers that includes hands-on training.

Successful completion and record of CPE activities in CPE Monitor is mandated in order for a pharmacist to receive credit for ACPE-accredited provider CPE activities. **You will be issued an inactive license if you have not completed required continuing education or are not exempt from completing continuing education. An inactive licensee may not practice pharmacy in Iowa.**

Disclosure of Medical Conditions, Criminal History, and Disciplinary Action:

Be advised that the application for pharmacist license renewal asks about any medical conditions you have that might impair your ability to perform the duties of a pharmacist. The Board also considers recent criminal history and disciplinary actions when renewing the license. As part of the application process you will be asked questions about any recent criminal history and disciplinary actions.

If you have any questions concerning these requirements, please notify the Board office. We suggest you contact the Board office for information as to what documentation may be necessary for licensure. Contacting the Board office about any of these situations may avoid unnecessary delays at the time of application.

Definitions (Important! Read these definitions before completing the following questions.)

"Ability to perform required pharmacist-related tasks with reasonable skill and safety" means ALL of the following:

- The cognitive capacity to use pharmacy systems to obtain necessary patient and prescription related information to process prescriptions
- The ability to effectively communicate information to other pharmacists, interns, providers, technicians, pharmacy support persons, and patients
- The ability to perform required tasks such as filling prescriptions, counseling patients, performing drug utilization reviews and other professional pharmacy services

"Medical condition" means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough such that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and perform the duties required of a pharmacist, or has adversely affected the ability to function and perform the duties required of a pharmacist within the past two (2) years.

"Improper use of drugs or other chemical substances" means ANY of the following:

- The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
- The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, or other chemical substance for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

Military veteran applicants are eligible for waiver of the initial application fee and one renewal fee if the applicant was honorably or generally discharged from federal active duty or national guard duty within five (5) years prior to application submission. **Applicants seeking waiver of the initial application fee or renewal fee must submit a copy of their Certificate of Release or Discharge from Active Duty (DD Form 214) or Verification of Military Experience and Training (VMET-DD Form 2586).**

Fees:

Renewal Application Fee Schedule – DO NOT SEND CASH		
Applications postmarked between May 1 and June 30	Renewal Fee	$180.00
Applications postmarked between July 1 and July 31	Renewal and Penalty Fee	$360.00
Applications postmarked between August 1 and August 31	Renewal and Penalty Fee	$450.00
Applications postmarked between September 1 and September 30	Renewal and Penalty Fee	$540.00
Applications postmarked between October 1 and October 31 (may require an appearance before the board)	Renewal and Penalty Fee	$630.00

Application and penalty fees are non-refundable administrative fees

Applications postmarked after October 31 are subject to reactivation provisions identified in Iowa Code Section 147.11.

Submit the completed application with all attachments and a check or money order made payable to the Iowa Board of Pharmacy in the appropriate amount to:

Iowa Board of Pharmacy, 400 SW 8th St Ste E, Des Moines, IA 50309

Information provided on this application may be disclosed pursuant to 657 IAC Chapter 14.

Iowa Board of Pharmacy
400 S.W. 8th St. Ste. E
Des Moines, IA 50309-4688
515-281-5944
https://pharmacy.iowa.gov/

PHARMACIST LICENSE RENEWAL APPLICATION

Please type or print legibly in ink. Complete all application sections and sign. **Incomplete or illegible forms will delay the renewal of your license. Refer to the application instructions for fee due.**

MILITARY STATUS		
Active Duty Military ☐	**Veteran** ☐	**Spouse of Active Duty Military** ☐
Waiver of new or initial renewal registration fee based on honorable or general discharge from military service within the past five (5) years. **Applicants seeking waiver of the initial application fee or renewal fee must submit a copy of their Certificate of Release or Discharge from Active Duty (DD Form 214) or Verification of Military Experience and Training (VMET-DD Form 2586).**		☐

License #:_____

LICENSEE INFORMATION							
Full Legal Name:	**(Last)**		**(First)**		**(Middle)**		
NABP e-profile ID:		**Previous/Other Name(s) Used:**					
PRIMARY ADDRESS:							
Street Address:							
Address:							
City:		**State:**		**Zip Code:**			
County:		**Email Address (*required*):**					
Telephone No. (*required*):	☐ Home ☐ Mobile If mobile, do you accept text messages ☐ Yes ☐ No						
MAILING ADDRESS (*if other than primary address*):							
Address:				**Suite #:**			
Address:							
City:		**State:**		**Zip Code:**			

PRIMARY EMPLOYMENT TYPE *(select one)*			
Community Pharmacy ☐	**Mail Order/Managed Care** ☐	**Hospital** ☐	**Long-Term Care** ☐
Home Health Care ☐	**Nuclear** ☐	**Correctional Facility** ☐	**Drug Wholesale/Distribution** ☐
Drug Manufacturer ☐	**Pharmacy-related education** ☐	**Government** ☐	**Consultant** ☐
Other Pharmacy-related ☐	**Unemployed, not retired** ☐	**Retired from Pharmacy Practice** ☐	**Engaged in Other Practices** ☐

CURRENT PHARMACY PRACTICE LOCATION *(Indicate your principal place of pharmacy employment)*					
Pharmacy Name:				**Pharmacy License No.:**	
Street Address:				**Suite #:**	
City:		**State:**		**Zip Code:**	
Are you the PIC:	☐ Yes ☐ No	**Date of hire if employment change since last renewal:**			

Nature and hours of pharmacy practice at this location ***(Indicate the number of hours worked per week next to the practice type)*****:**		
Community	**Long-Term Care**	**Mail Order**
Hospital-dispensing	**Hospital-clinical**	**Home Healthcare**
Industry	**Nuclear**	**Consulting**
Compounding-sterile	**Compounding-non sterile**	**Correctional**
Telepharmacy-consulting	**Telepharmacy-dispensing**	

RESIDENCY			
Residency PGY1			
Institution Name:		**Location:**	
PGY1 Program:			
Residency PGY2			
Institution Name:		**Location:**	
PGY2 Program:			
Residency PGY1 & PGY2 Combined Program			
Institution Name:		**Location:**	
PGY 1&2 Program:			

LICENSE INFORMATION *(List all states in which you are currently licensed to practice pharmacy)*				
State:	**License No.:**	**Date Issued:**	**Expiration Date:**	**Status:**

BOARD CERTIFICATIONS (BPS)					
Certification Type:	**Certification #:**	**Status:**	**Original Date:**	**Effective Date:**	**Expiry Date:**

CONTINUING EDUCATION *(review application instructions before completing this section)*

CE renewal period is the 27-month period commencing April 1 prior to the previous license expiration and ending June 30, the date of current license expiration.

Are you a resident of and are you currently licensed to practice pharmacy in another state that requires continuing education for pharmacist licensure? If yes, indicate the state and license expiration date. Out of state licensure and residence combine to satisfy Iowa's C.E. requirements UNLESS you are practicing pharmacy in Iowa. If you qualify under this provision, skip to Statewide Protocols

YES ☐ NO ☐ If yes, State _____ License No. _____ License Expiration Date _____

Is this your first license renewal following Iowa licensure by examination? If yes, you are exempt from Iowa's continuing education requirement for this renewal only, skip to Statewide Protocols ☐ YES ☐ NO

I hereby certify, by initialing following this statement, that I have completed the required 30 contact hours (3.0 CEs) of continuing education as provided by Board rules at 657-2.12 OR that I have completed a CPD portfolio as provided by Board rules at 657-2.17. I further certify that none of the credits relied on for this license renewal have previously been used for Iowa license renewal and that all credits relied on for this license renewal were obtained during the 27 month C.E. renewal period identified above. _____(initials)

STATEWIDE PROTOCOLS

Are you an authorized pharmacist who orders and administers vaccines? ☐ YES ☐ NO

If yes, have you completed at least one hour of ACPE-accredited continuing education with the ACPE topic designator "06" followed by the letter "P." ☐ YES ☐ NO

Are you an authorized pharmacist who orders and dispenses naloxone? ☐ YES ☐ NO

If yes, have you completed at least one hour of ACPE-accredited continuing education related to naloxone utilization (not required for each renewal)? ☐ YES ☐ NO

Are you an authorized pharmacist who orders and dispenses nicotine-replacement tobacco cessation products? ☐ YES ☐ NO

If yes, have you completed at least one hour of ACPE-accredited continuing education related to nicotine-replacement tobacco cessation product utilization (not required for each renewal)? ☐ YES ☐ NO

CRIMINAL HISTORY *(If you answer yes, you must list all convictions below, attach additional pages if necessary. On a separate sheet of paper provide a signed and dated explanation and attach court records of the conviction(s))*

Since your last renewal, do you have any pending charges, or been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime other than a minor traffic offense, in any jurisdiction? You must disclose all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. (For example, you must report if your conviction was expunged, you received a deferred judgment, or you received an executive pardon.)

☐ YES ☐ NO

DISCIPLINARY HISTORY (*includes, but is not limited to: citations, reprimands, fines, license or registration restrictions, probation, surrender, suspension, and revocation. If you answer yes to any of the questions below provide a description and attach final disciplinary orders)*		
Since your last renewal have you been disciplined by any licensing authority?	☐ **YES**	☐ **NO**
Do you have any charges, or knowledge of any complaints or investigations, pending before any licensing authority?	☐ **YES**	☐ **NO**
Since your last renewal have you been denied a license or registration by any licensing authority?	☐ **YES**	☐ **NO**

MEDICAL CONDITION (*If you answer yes to any of the questions below, on a separate sheet of paper provide a signed and dated explanation.)*		
Do you currently have a medical condition that in any way impairs or limits your ability to perform the duties of a pharmacist with reasonable skill and safety?	☐ **YES**	☐ **NO**
Are you currently engaged in the illegal or improper use of drugs or other chemical substances?	☐ **YES**	☐ **NO**
Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to perform the duties of a pharmacist with reasonable skill and safety?	☐ **YES**	☐ **NO**
If YES to any of the above, are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?	☐ **YES**	☐ **NO**
If YES to any of the above, does your field of work, the setting, or the manner in which you perform the duties of a pharmacist, reduce or eliminate the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?	☐ **YES**	☐ **NO**

I hereby swear or affirm under penalty of perjury that the information provided in this application is true and correct. I understand that failure to provide complete and truthful information may constitute grounds for denial, revocation, or other disciplinary sanctions against my pharmacist license. Information provided on this application may be disclosed pursuant to 657 IAC Chapter 14.

REQUIRED SIGNATURE:

Signature of Licensee: _____ Date: _____

Privacy Act Notice: Disclosure of your Social Security number on this application is required by 42 U.S.C. § 666(a)(13) and Iowa Code §§ 252J.8(l), 261.126(1), and 272D.8(1). The number will be used in connection with the collection of child support obligations and debts owed to the state of Iowa, and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code § 421.18.

Reminder: Iowa law requires a pharmacist to notify the Board within 10 days of a change of legal name, residence address, or employment.